DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/29/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULT	NULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		445162	B. WING		R		
	ROVIDER OR SUPPLIER	<u></u>] 1	REET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604		22/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 280 SS=D	was completed for survey conducted of first follow-up visit substantial complia plan of correction at August 10, 2012. F-323 was recited apreviously cited on 483.20(d)(3), 483.1 PARTICIPATE PLATE P	2012 a first follow-up survey the annual recertification on June 16, 2012. During the tag F-323 was found not in ance as stated on the facility's alleging a compliance date of and a new tag, F-280, not the annual survey, was cited. IO(k)(2) RIGHT TO ANNING CARE-REVISE CP are right, unless adjudged erwise found to be or the laws of the State, to ing care and treatment or different treatment. For the laws of the state, to ing care and treatment or different treatment. For the laws of the state, to ing care and treatment or different treatment. For the laws of the state, to ing care and treatment or different treatment or different treatment. For the laws of the state, to ing care and treatment or different treatment or different treatment. For the laws of the state, to ing care plan must be developed the completion of the sessment; prepared by an important treatment or different treatm	F 280	The filing of this Plan of Correction does not constitute admission that the deficier alleged did, in fact, exist. Plan of Correction is filed evidence of the facility to with the requirement of participation and continue provide high quality reside the planning care-revise CP 1. On 8/22/12, foley cathed was updated on the Care for Resident #2, #14, & the D.O.N. and/or A.D.O. 2. The DON or one of the following: ADON, RN Supervisor, Wound Care LPN Supervisor, or the Nurse will audit all Resing Care Plans to ensure the include correct foley cathed the completed by 8/23/12. 3. By 8/24/12, the DON are	cies This as comply e to ent care. er care e Plan e #9 by D.N. Charge dent's y heter	8/23/12	
	by:	NT is not met as evidenced		ADON will re-educate l			
	Nork de JU	ERISUPPLIER REPRESENTATIVE'S SIGNA	ATURE	Administrator		(X8) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CWKE12

Facility ID: TN9003

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/29/2012 FORM APPROVED OMB NO. 0938-0391

		CA INCEDIONID OF IVAICES				OMP MO	, 0930-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R		
	·	445162	B. Wii	NG		08/2	08/22/2012	
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
ASBURY	ASBURY PLACE AT JOHNSON CITY			105	5 WEST MYTRLE AVENUE PHNSON CITY, TN 37604			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1D	<u> </u>	PROVIDER'S PLAN OF CORRE	CTION	T NO	
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SECTION SEC	KOULD BE	(X5) COMPLETION DATE	
F 280	Continued From pa	ae 1	.	280	nursing staff on updatin	g the		
		record review and interview,	' '	200	care plan with foley cat] .	
	the facility failed to	record review and interview, revise the care plan for three		1	information.	10001	}	
	residents (#2, #9, a	nd #14) of eighteen residents			information.			
	reviewed.				The DON or one of the			
	The findings include	ad.			following: ADON, RN			
	The mange morad				Supervisor, Wound Car	e Nurse.	1	
	Resident #2 was ad	imitted to the facility on			LPN Supervisor, or the			
	February 22, 2012, with diagnoses including Paranoid Schizophrenia, Venous Stasis Ulcers,			ţ	Nurse will conduct rand		1	
					•			
	and Hypertension.			- 1	audits of resident care p			
	Madical second			- [indwelling foley cathete		i .	
	dated by 17 2012	ew of a physician's order			ensure correct foley cat			
	foley catheter if doe	2, revealed "may replace es not void before 7pm			information is on the ca			
	tonight"			i	Audits will be complete]]	
	_				residents per week for 4		1	
	Medical record revi				then 10 residents per me			
		re Plan last reviewed August			3 months. To begin 8/2	9/12.	!	
		no updates to reflect the was discontinued on July 17,				*** *	ļ	
	2012.	was discontinued on July (7,			4. The results of the audits		! !	
S					reviewed at the Quality		ļ į	
		ssistant Director of Nursing			Assurance Committee ([[
		22, 2012, at 11:40 a.m.,		ŀ	Administrator, Facilitie		į I	
-		Plan had not been revised to			Director maintenance a			
į		no longer had an indwelling			housekeeping, MDS, Pl	iarmacy,		
	uninary catheter.				Social Services, Medica	al		
1	Resident #9 was ad	mitted to the facility on July 9,			Director, ADON, Dinin	g		
	2010, with diagnose				Services) meeting mon		ĺ	
		Dementia, and Incontinence.			three (3) months and	•		
ì					recommendations made	as		
		ew of the physician's			appropriate. To begin			
ľ		s dated August 2012,			August data at the Sept	emher	į	
		20 Fr (French) Foley cath				CHIOCI		
	(catheter) prn (as no	seaea)		ı	Q.A. meeting.			
Į				i				

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Event ID: CWKE12

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/29/2012 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445162	B. WIN	1G		R	
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			10	EEY ADDRESS, CITY, STATE, ZIP CODE DE WEST MYTRLE AVENUE OHNSON CITY, TN 37604	08/	22/2012	
(X4) ID PREFIX TAG			ID PREFI TAG	х	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION OATE
F 280	Medical record reviended interdisciplinary Care 14, 2012, revealed month and PRN" Interview with the Ad (ADON) on August 2 confirmed the Care reflect the resident's was to be changed at the confirmed at the care reflect the resident's was to be changed at Resident #14 was at 21, 2012, with diagnal Disease, Diate Hypertension. Medical record revience recapitulation orders revealed "change interdisciplinary Care	ew of the current e Plan last reviewed August 'foley cath change Q (every) essistant Director of Nursing 22, 2012, at 11:40 a.m., Plan had not been updated to indwelling urinary catheter as needed not every month. dmitted to the facility on April oses including End Stage betes Mellitus, and ew of the physician's iddated August 2012, foley cath prn"	F 2	80			
(F 323) SS=D	Interview with the As (ADON) on August 2 confirmed the Care I reflect the resident's was to be changed a 483.25(h) FREE OF HAZARDS/SUPERV The facility must ensenvironment remains as is possible; and en	ISION/DEVICES ure that the resident as free of accident hazards	{F 32:	3}			8/22/12

2012-09-04	13:00
DEBARTHE	

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DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				PKW I EL	U9/U4/ZU1
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					APPROVED
Statemei	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	JLTIPLE CONS	TRUCTION	(X3) DATE S COMPLI	. 0938_0399 URVEY ETED
		445162	B. WIN	g		ì	R
NAME OF	PROVIDER OR SUPPLIER	443102					2/2012
ASBUR	Y PLACE AT JOHNSO			105 WEST 8	iess, city, state, zip code Mytrle avenue I City, tn 37604		
(X4) ID PREFIX TAG	1 (EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRE ACH CORRECTIVE ACTION SI SS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(XS) COMPLETION DATE
(F 323)	Continued From pa as is possible; and adequate supervision prevent accidents.	ge 3 nach resident receives on and assistance devices to	{F 32	F323 Hazai	Free of Accident rds/Supervision/De		
	by: Based on medical: review, observation, failed to ensure a sa one resident (#10), side rails after a fall (#12), and failed to	record review, facility policy and interview, the facility fety device was in place for falled to reduce or eliminate from the bed for one resident nvestigate a fall for one teen residents reviewed.		1.	On 8/22/12, the A immediately re-as Resident #12 relat rail use. Side rails discontinued and to placed in the lower position.	sessed ted to side were the bed	
	December 27, 2012, Dementia with Beha Agitation. Madical record revie (MDS) dated June 2 resident was cognitionaking, required extends to the property of the	dmitted to the facility on with diagnoses including viors, Depression, and w of the Minimum Data Set 2, 2012, revealed the rely intact for daily decision			On 8/22/12, the C Nurse replaced the resident #10. On 8/23/12, the C Nurse completed a incident report to missing one for the fall incident on resident	e PSA for harge a 2 nd replace the e 8/10/12	
İ	Medical record reviee Care Plan last revise "ls at risk for falls d while transferringa: footwearinstruct on	w of the interdisciplinary d August 8, 2012, revealed //t (due to) unsteady balance ssist to wear non-slick safety measures to reduce (personal safety alarm) wc		2.	The DON or one of following: ADON Supervisor, Wound Nurse, LPN Super	I, RN ad Care	

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Event IQ: CWKE12

Facility ID: TN9003

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2012-09-04 13:00

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PRINTED: 09/04/201

DEPARTMENT OF HEALTH AND HUMAN SERVICES	PKIN1ED: 08/04/201
CENTEDS COR MEDICARE A MEDICARE	FORM APPROVE
CENTERS FOR MEDICARE & MEDICAID SERVICES	OM5 NO. 0938-039
STATEMENT OF DESIGNATION	OMO 1407, 0500-059

AND PLAN OF CORRECTION A SULDING STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	DC21 MUI	LTIPLE CONSTRUCTION		(X3) DATE SURVEY		
MANE OF PROVIDER OR SUPPLIER ASBURY PLAGE AT JOHNSON CITY SUMMARY STATEMENT OF DEFICIENCIES (PART IN CONTINUE AND PROPERTY AND PROPER	I AND PLAN	of Correction	IDENTIFICATION NUMBER:			COMPL	ETED ETED	
ASBURY PLACE AT JOHNSON CITY PARTY TAG SUMMANY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECODED BY FULL REGULATORY OR LOC IDENTIFYING INFORMATION) (F 323) Continued From page 4 Medical record review of the physician's recapituation orders dated August 2012, revealed "Parsonal safety device due to decreased safety swareness" Observation on August 22, 2012, at 5:20 a.m., in the resident's trion or nevealed the resident lying on the bed with no personal safety alarm in place. Observation on August 22, 2012, at 10:05 a.m., with Clerified Nurse Aide (CNA) #1, revealed the resident sitting in a wheelchair. Continued observation and interview revealed no Personal Safety Alarm in place. Observation on August 22, 2012, at 10:45 a.m., with Licensed Practical Nurse (IPN) #1, revealed the resident sitting in a recinier, in the residents room. Continued observation and interview revealed no PSA in place. Interview with the Assistant Director of Nursing (ADON) on August 22, 2012, at 11:50 a.m., in the conference room, confirmed the facility failed to ensure a Personal Safety Alarm was in place for resident #10. Resident #10. Resident #12 was admitted to the facility on July 27, 2011, with diagnoses including Chronic Heart Disease, Dysphagia, and Altered Mental Slatus. Medical record review of the Minimum Data Set (MDS) dated July 31, 2012, revealed the resident with transfers and walking in coom, and not steed more resident experience and continued on the severe cognitive impairment, independent with transfers and walking in coom, and not steed work and a complete on the process of the following: ADON, RN Supervisor, Wound Care Nurse, LPN Supervisor,			445162	B. WING		084	-	
### TAS Facility	·			1	106 WEST MYTRLE AVENUE		CA2012	
Medical record review of the physician's recapitulation orders dated August 2012, revealed "Personal safety device due to decreased safety awareness" Observation on August 22, 2012, at 8:20 a.m., in the resident's room, revealed the resident lying on the bed with no personal safety alarm in place. Observation on August 22, 2012, at 10:05 a.m., with Certified Nurse Aide (CNA) #1, revealed the resident sitting in a wheelchair. Continued observation and interview revealed no Personal Safety Alarm in place. Observation on August 22, 2012, at 10:45 a.m., with Licensed Practical Nurse (LPN) #1, revealed the resident's string in a recifience, in the resident's string in a recifience, in the resident's troom. Continued observation and interview revealed no PSA in place. Interview with the Assistant Director of Nursing (ADON) on August 22, 2012, at 11:50 a.m., in the conference room, confirmed the facility failed to ensure a Personal Safety Alarm was in place for resident #10. Resident #12 was admitted to the facility on July 27, 2011, with diagnoses including Chronic Heart Disease, Dysphagia, and Altered Mentel Status. Medical record review of the Minimum Data Set (MDS) dated July 31, 2012, revealed the resident with transfers and walking in room, and not stagity moving from resident to receive received in the recipient of the recipient of the facility of the recipient of the resident of the res	PREFIX	! (EACH DEFICIENCY	MUST BE PRECEDED BY FILL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ÓN SHÓULD BE IE APPROPRIATE	COMPLETION	
		Medical record revieurecapitulation orders revealed "Persons decreased safety at Observation on Aug the resident's room, the bed with no personal of the certified Nurse resident sitting in a vobservation and inte Safety Alarm in place Observation on Aug with Licensed Practithe resident sitting in room. Continued observation on Aug with Licensed Practithe resident sitting in room. Continued observation on Aug with Licensed Practithe resident sitting in room. Continued observation on August 2 conference room, consure a Personal Stresident #10. Resident #12 was ac 27, 2011, with diagnous conference room, consure a Personal Stresident #10. Resident #12 was ac 27, 2011, with diagnous conference room, consure a Personal Stresident #10. Resident #12 was ac 27, 2011, with diagnous conference room, consure a Personal Stresident #10. Resident #12 was ac 27, 2011, with diagnous conference room, continued observed and stresident #12 was acconference room, continued observed with transfers and was acconference room, continued observed was acconference room, co	ew of the physician's stated August 2012, all safety device due to wareness" Just 22, 2012, at 8:20 a.m., in revealed the resident lying on sonal safety alarm in place, aust 22, 2012, at 10:05 a.m., Aide (CNA) #1, revealed the wheelchair. Continued erview revealed no Personal ee, ust 22, 2012, at 10:45 a.m., cal Nurse (LPN) #1, revealed a recliner, in the resident's eservation and interview place. Sistant Director of Nursing 12, 2012, at 11:50 a.m., in the infirmed the facility failed to afety Alarm was in place for limitted to the facility on July bases including Chronic Heart and Altered Mental Status. W of the Minimum Data Set 2012, revealed the resident impairment, Independent ulking in room, and not	{F 323	care plans to ensu include current fa interventions. To completed by 8/2. The D.O.N. and A completed an audiresidents with side ensure side rails wappropriately disc from residents whe experience a fall fibed. Completed of the complete of the	ine they ill be 3/12. A.D.O.N. it of all e rails to ere continued to had from the on 9/4/12. ON will in- eff in corting, fall fating		

FORM CMS-2567(02-99) Pravious Versions Obsolete

Event (D: CWKE12

Facility ID: YN9003

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2012-09-04 13:01

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9752000 P 7/9

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 445162 08/22/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE ASBURY PLACE AT JOHNSON CITY JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY {F 323} random audits of resident Continued From page 5 (F 323) care plans to ensure current Medical record review of a nurse's note dated August 17, 2012, at 2:30 a.m., revealed fall interventions are "...resident observed lying on R (right) side in reflected on the care plan. front of roommate's bed..." One of the individuals listed Medical record review of the interdisciplinary notes dated August 17, 2012, at 9:00 a.m., above will conduct random revealed "...observed in floor of room...bed alarm audits to ensure fall placed on bed to alert staff of unassisted interventions are in place via ambulation..." walking rounds. Medical record review of the interdisciplinary Care Plan last revised August 17, 2012, revealed Audits will be completed on "...at risk for falls d/t (due to) unsteady gait, 10 residents per week for 4 balance and hx (history) of fails...encourage to weeks, then 10 residents per wear non-slick footwear...bed alarm...SR's (side rails) x (times) 2 per request bed month for 3 months. To mobility...encourage to ask for assist prior to begin the week of 9/3/12. transfer/ambulation attempts...side rails as ordered..." 4. The results of the audits will Review of the facility's Fall Investigation Tool, be reviewed at the Quality dated August 17, 2012 revealed when the fail Assurance Committee occurred on August 17, 2012, the resident stated (DON, Administrator, "I just fell". Continued review revealed the Facilities Director ...ordered restraint side rail device was in maintenance and place..." Continued review of the Fall Investigation Tool revealed no investigation as to housekeeping, MDS, determine how the resident exited the bed while Pharmacy, Social Services, the side rail device was in place. Medical Director, ADON, Review of facility policy, Falls Investigation Dining Services) meeting Procedure, dated January 2008, revealed "...if a monthly for three (3) months fall occurs, the falls investigation tool is followed and recommendations made to ensure that the resident receives timely and as appropriate. August data appropriate care as well as follow up notifications

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and documentation...an investigation to assist in determining the root cause of the fall as well

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to be reviewed at September

O.A. meeting and September

DEPAR	2-04 13:01 RTMENT OF HEALTH RS FOR MEDICARE	DC0547PM13501 I AND HUMAN SERVICES & MEDICAID SERVICES	86	52125642 >>	FOR	P 8/9 D. UNIVERZUIZ M APPROVED
ISTATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	<u>0.0938-0391</u> survey Leteo
		445162	B. WING			R 22/2012
Į.	PROVIDER OR SUPPLIER PLACE AT JOHNSO		10	EÉT ADDRESS, CITY, STATE, ZI 5 WEST MYTRLE AVENUE DHNSON CITY, TN 37604	IP CODE	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix TAG	Provider's Plan of (Each Corrective ac Cross-Referenced to Deficien	THE APPROPRIATE	COMPLETION DATE
	August 17, 2012, re experienced a fall or Continued review of "resident observed Observation on August 16 resident's room, the bed with two one the middle of the bed Interview with the As (ADON) on August 2 confirmed the resident erails in the up positiouse while the resident erails in the up positiouse while the resident 2012, when the side Resident #7 was adra 16, 2009, with diagnowithout Behaviors, O Alzheimer's Disease. Review of the significant properties of the significant significant significant properties of the significant significant significant properties of the significant	of fall initiated" ew of a Therapy Screen dated vealed the resident had not August 17, 2012. The Therapy Screen revealed of an floor in room" sust 22, 2012, at 8:20 a.m., in revealed the resident lying on a half side rails attached to do in the up position. esistant Director of Nursing 22, 2012, at 9:10 a.m., and had experienced a fall sust 17, 2012. The ADON exited the bed with the side in the side rails remained in the side rails remained in the side rails remained in the side of the side calls remained in the side of the facility on April cases including Dementia steoporosis, Depression and cant change Minimum Data 012, revealed the resident ifteen on the Brief Interview MS) indicating the resident	{F 323}			

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Observation on August 22, 2012, at 8:17 a.m., in

Event ID; CWKE12

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2012-09	-04 13:01	DC0547PM13501		86	52125642 >>	9752000	P 9/9		
DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				FORK	APPROVED		
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES). Q938-0391		
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIF	PLE CONSTRUCTION	(X3) DATE:			
	o opinion	IDENTIFICATION NUMBER:	A. BUIL	DING.	3	COMPI	ETED		
		445162	B. WIN	٥_			R		
NAME OF P	ROVIDER OR SUPPLIER	-11002					22/2012		
ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Yement of deficiencies Must be preceded by full SC identifying information)	ID PREFD TAG	,	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
(F 323)	the 100 Wing Hallw sitting in the hallway alarm in place. Review of facility po Procedure, dated Ji	ge 7 ay, revealed the resident y in the wheelchair with a chair plicy, Falls Investigation anuary 2008, revealed "If a investigation tool is followed	(F 32	:3)					
	to ensure that the re- appropriate care as and documentation, determining the roo classifying the type interventions are ch result of the investig	esident receives timely and well as follow up notificationsan investigation to assist in t cause of the fail as well of fall initiatedCare plan anged or developed as a pation"							
!	August 22, 2012, at room, revealed the	irector of Nurses (DON) on 10:30 a.m., in the conference facility did not have an fall on August 10, 2012.							
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		}							

Event ID: CWKE12

2012-09-04 13:01

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